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August 28, 2015

ADDENDUM # 1

RFP: 7549802

Title: EOHHS –Certified Medicaid Accountable Entities

Bid Closing Date & Time: September 10, 2015 at 10:00 AM (Eastern Time)

Notice to Vendors:

ATTACHED ARE VENDOR QUESTIONS WITH STATE RESPONSES.
NO FURTHER QUESTIONS WILL BE ANSWERED.

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Interdepartmental Project Manager

Interested parties should monitor this website, on a regular basis, for any additional information that may be posted.

Vendor Questions with State Responses for RFI #7549802
EOHHS- Certified Medicaid Accountable Entities

Question 1: As to the pilot program, is it the intent of the State to approve more than one (1) Accountable Entity (AE) for the one (1) year pilot?

Answer to question 1:

EOHHS intends to certify at least one pilot AE, serving at least 25,000 members under a fully delegated global capitation contract. The pilot AE(s) will be selected based on the process described in Part E. The number of pilot AEs selected will depend upon the applications received.

Question 2: With regard to an AE submitting certification commitments and the selection of an AE(s) for the pilot, if the AE does meet all of the certification standards for Level 3 (as described in Part B and Appendix A) by January 2016, must the future date to meet said certifications agreed upon by the state and the AE be within the one (1) timeframe of the pilot?

Answer to question 2:

EOHHS recognizes both the importance of appropriate standards of consumer protection and the challenge for prospective AEs in meeting these timelines. We would appreciate feedback on which specific standards would be most challenging for prospective AEs and realistic timelines by which they might be met.

We would also appreciate feedback on the most critical standards to ensure that Medicaid recipients have access to high quality care that meets or enhances the triple aim and accomplishes the four principles articulated in Section 3.0 Part B of the Request for Information.

Question 3: In an MCO, "social determinants" are often an important part of the services provided to members. How will these services be quantified? Will access to care and impact on health be measured independently?

Answer to question 3:

EOHHS recognizes that it is critically important for social determinants to be incorporated into the care model for any effective Accountable Entity serving Medicaid members. We are currently looking to recent CMS guidance and other state experiences (e.g., Oregon, Minnesota) for learnings to inform these standards. We are very interested

in feedback on how best to integrate social determinants into the draft certification standards, financial arrangements and metrics.

Question 4: Accurate data and analytic reporting are imperative to numerous facets of this project. How will the state work with and regulate ACE(s) to ensure that accurate data is being collected and reported? Will claims data be utilized as part of a larger health information exchange, or increased data sharing between providers?

Answer to question 4:

EOHHS recognizes that accurate data and strong analytic reporting capacity are critical to an effective accountable care model. We welcome comments as to whether and how the standards established in Part C Section 4 should be enhanced or modified.

EOHHS also expects that certified Accountable Entities will need to increase data sharing between providers and partners. We welcome comments as to whether the Governance standards proposed in Part C Section 3 are an adequate/appropriate mechanism to encourage such integration.

Question 5: Are there plans in place to address EMR interoperability issues between providers?

Answer to question 5:

EOHHS acknowledges that EMR interoperability is an important issue for developing AEs, and a fundamental capacity that is needed to support the goals of Reinventing Medicaid and the principles established in Part B of the Request for Information. We welcome specific recommendations and enhancements to the standards proposed in Part C Section 4 that would encourage/support EMR interoperability.

Question 6: How does the state plan to capture clinical quality measures? Especially from long term care providers?

a. Will these measures be derived from CMS' Nursing Home VBP Demonstration (2009-2012) and other state-run programs?

Answer to question 6:

EOHHS is interested in specific comments on whether and how an AE could provide comprehensive clinical performance measures, and in addition, what specific measures we might require.

Question 7: Will EOHHS be engaging other states, or stakeholders, who have transitioned to these models to garner insights into best practices, lessons learned, or potential program problems?

Answer to question 7:

EOHHS recognizes that there are many best practices and lessons to be learned from other states as well as local stakeholders engaged in Accountable Care models for other market segments. As such we are currently participating in a learning collaborative facilitated by the Center for Health Care Strategies (CHCS) with several states who have transitioned or are in the process of transitioning to accountable care models. This Request for Information was specifically intended to garner insights from local stakeholders. We would appreciate any suggestions of specific states or stakeholders that might provide important insights and/or applicable lessons for Rhode Island. Public meetings will be held this fall to encourage additional stakeholder feedback.

Question 8: Will there be multiple ACEs for specific patient populations?

Answer to question 8:

As stated in in Part C Section 3 Governance, EOHHS is specifically seeking comments on provider exclusivity requirements. Should providers who are financially accountable members of an AE, participating in the risk/reward of the accountable entity, be allowed to participate in the networks of multiple accountable entities? Should primary care providers be required to be exclusive to a specific accountable entity? What about specialists? Should members actively select an AE?

Question 9: Are the terms "Accountable Entity" (as found on page 5) and "Accountable Care Organization" (as found of page 9) being used interchangeably? If not, please distinguish the differences.

Answer to question 9:

Accountable Care Organization is intended as a more generic concept for this type of care delivery model. Certified Accountable Entity (AE) is the specific term EOHHS is currently using to define those entities that meet the standards established in Part C.

Question 10: Goals listed on page 8 include "Encourage the development of accountable entities for integrated long-term care". This RFI seems to envision a much broader provider base than just long-term care. Would EOHHS consider a proposal specific to long-term care?

Answer to question 10:

EOHHS is interested in feedback and recommendations regarding specialized Accountable Entities. Should EOHHS consider/allow specialized, population specific accountable entities? If so, should all accountable entities be held to the same certification standards? If not, how specifically should these standards be tailored to support specialized AEs?

Question 11: Page 9 references a "pilot Accountable Entity" for which the state is seeking "immediate certification standards and contractual requirements". Has the State identified a partner to serve as this pilot? Will there be more than one AE in the pilot?

Answer to question 11:

EOHHS intends to certify at least one pilot AE, serving at least 25,000 members under a fully delegated global capitation contract. The pilot AE(s) will be selected based on the process described in Part E. The number of pilot AEs selected will depend upon the applications received.

Question 12: Page 10 references an "intermediate structure for financial alignment". Please define or elaborate. Is "intermediate" used to define a specific financing structure, or does it mean this financing model will be temporary?

Answer to question 12:

"Intermediate" in this instance is based on the definition "something in between two things", and is intended to refer to the structures, or Accountable Entities, that sit between the specific provider organizations and the contracting entity (in this instance, the MMCOs).

Question 13: Would EOHHS consider an extended time frame for assuming a higher % of risk? (i.e. 5 yrs.)

Answer to question 13:

EOHHS is committed to the principles of payment articulated in Part D Section 2:

- .All parties need some financial incentives to manage care – MCOs, AEs, State.
- Partnership creates common priorities.
- Risk potential must be adjusted based on meeting performance standards and quality metrics.

The state seeks feedback on specific arrangements and time horizons in accordance with these principles.

Question 14: EOHSS is looking to 'certify' an AC – what will certification process entail; How will the process be conducted?

Answer to question 14:

As stated in Part E, an application to be certified as an Accountable Entity will be posted by the state. Candidates must then submit certification commitments, to be reviewed and approved by EOHHS. MMCOs will then be required to contract with Certified AEs.

Question 15: Can you provide examples of non-medical services (i.e. those that address social determinants) that would be acceptable to CMS?

Answer to question 15:

EOHHS recognizes that it is critically important for social determinants to be incorporated into the care model for any effective Accountable Entity serving Medicaid members. We are currently looking to recent CMS guidance and other state experiences (e.g., Oregon, Minnesota) for learnings to inform these standards.

See the attached CMCS Informational Bulletin, dated June 26, 2015, which is "*intended to help states design benefit programs that acknowledge the social determinants of health, and contribute to a holistic focus on improvement of individual health and wellness*."

http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

Question 16: Would an agency that had an EMR but did not meet stage 1/2 meaningful use be eligible for inclusion?

Answer to question 16:

The standards proposed in Part C Section 4 state that a certified AE must "meet stage 1 meaningful use conditions as a Level 1 or 2 AE". However, these standards are intended as a starting point for purposes of encouraging meaningful and specific input. EOHHS welcomes feedback as to whether this requirement is critical to achieving an accountable care model that is prepared to meet the challenges of the next generation of managed care and the triple aim. Would this standard act as a barrier to local providers? How might we refine this standard to reduce such barriers?

Question 17: What carve outs would you consider? Hospice? Other?

Answer to question 17:

As described in Part C Section 2, EOHHS "intends that the entities be held accountable to total cost of care including a full spectrum of services, including primary, specialty, behavioral health, dental and long term care services as appropriate to serve the specified

population". The proposed standards do not specify allowable carve outs – instead, requiring Certified AEs to capture a specified percentage of cost at different levels of Certification. Under this proposed standard, hospice COULD be carved out, as long as the required percentage of cost is captured.

EOHHS seeks comments on the benefits and challenges of including/requiring specific services, such as hospice, in the required spectrum of services of a certified Accountable Entity.

Question 18: Would EOHHS consider less than 5000 enrollees as a minimum?

Answer to question 18:

As described in Part C Section 5, EOHHS recognizes that minimum volume thresholds are important to ensure that entities can reasonably be held accountable to the total cost of care. The proposed standard would require that certified AEs be responsible for the total cost of care associated with a minimum of 5,000 Medicaid enrollees, however EOHHS seeks comments on the necessary minimum number of enrollees for successful care management and risk.

Question 19: In Medicare ACO the attribution of members is thru the PCMH – what attribution methodology is EOHHS considering - If it is not thru the PCMH – then how would the tracking of members be done?

Answer to question 19:

The proposed attribution method is described in Part D Section 2, on page 19.

Question 20: Would EOHHS consider metrics for addressing social determinate issues? (i.e. # of housing placement, # of SNAP benefits)

Answer to question 20:

EOHHS recognizes that it is critically important for social determinants to be incorporated into the care model for any effective Accountable Entity serving Medicaid members. We are currently looking to recent CMS guidance and other state experiences (e.g., Oregon, Minnesota) for learnings to inform these standards. We are very interested in feedback on how best to integrate social determinants into the draft certification standards, financial arrangements and metrics.

Question 21: Regarding Certified Accountable Entities' ability to predict and measure changes in cost of total care and it ability to fully coordinate care, **can the State provide information on how it will facilitate access to data from the All-Payer Database and CurrentCare?**

Answer to question 21:

EOHHS recognizes that in order to move to a more accountable model of care, AEs must have access to real time or near real time data and have the analytic capacity to effectively use that data to inform care.

The proposed Data/Analytics Capacity standards described in Part C Section 4 are intended to ensure that AEs have sufficient data/analytic infrastructure in place to support effective care coordination and total cost of care models. EOHHS would appreciate feedback as to whether the proposed standards adequately ensure that certified AEs have established such an infrastructure.

EOHHS also requests comments on the additional data needed, beyond what could reasonably be captured internally by the AE, to support effective care coordination and what specific standards the state might establish to help facilitate AE access to such information. Please comment as to whether access to state datasets is needed to accomplish the goals in the RFI and which datasets may be needed.

Question 22: This RFI provides considerable detail on the proposed expectations for AEs. **Can the State provide more detail on its expectations or requirements for MCO in this new arrangement?** For example, **will the MCOs be required to share claims data?**

Answer to question 22:

As described in Part D Section 1 Interaction with Health Plans, the state proposes to continue to contract with MCOs to provide care to Medicaid enrollees in a capitated model. The state seeks comments as to the advantages and risks of such an approach.

The state also seeks comments as to the appropriate and responsive roles of the two parties. At a minimum MCOs would be required to contract with Certified AEs, in accordance with the financial terms as proposed in Part D Section 2. However EOHHS also recognizes that a key driver of success for these Accountable Entities will be access to data and information to support data driven decision-making. As such, MCOs may be required to support the AEs with tools to access near-real time provider specific claims;

and/or AE aggregated performance data and population based outcome measures. EOHHS seeks comments on the advantages and disadvantages of such an approach, and any recommended additional requirements for participating MCOs that would facilitate a successful AE partnership.

Question 23: Pages 17-19 suggest that the State will set a capitation and that if actual costs are lower than the capitation the resulting savings will be shared by the State, the MCO, and the AE – with the allocation of upside and downside risk depending on the AE Level. **Does this imply that MCOs will not be at full risk for financial results? Please explain the anticipated flow of funds and allocation of risk from the state to the MCO to the AE. Will the risk exposure vary between MCOs? Please explain what factors would define any variation. Examples would be most helpful.**

Answer to question 23:

The proposed Payment Model described in Part D Section 2 is based on three preliminary principles of payment as specified on page 19:

- All parties need some financial incentives to manage care – MCOs, AEs, State
- Partnership creates common priorities
- Risk potential must be adjusted based on meeting performance standards/quality metrics

EOHHS intends therefore for risk to be shared amongst the three parties – MCOs, AEs and the state, in the manner described in Figure 1 on page 18. The initial relationship would be between the state and the MCO – with MCOs accountable for up to 90% of the risk in a Level 3 arrangement. The MCO then contracts with certified AEs, sharing up to half of this risk with partner AEs.

EOHHS welcomes feedback on the principles of payment specified above and on page 17. EOHHS also welcomes feedback on the appropriate level of risk sharing between the state and the MCOs, and correspondingly between the MCOs and AEs, at varying levels of AE certification. How much risk exposure should be transferred from the state to MCOs? From MCOs to the AEs? Should these models vary between MCOs?

Note that the proposed pilot arrangement, described on page 20 in Part E, would not be a shared risk but rather a fully delegated global capitation arrangement, with payment set at 95% of current MMCO payment rates.

Question 24: Today's MCO capitation rates assume managed care savings and use the savings to fund the MCOs' administration costs. **How will MCOs cover their administration costs if they retain less than ½ of savings? Please explain how MCOs will be able to cover their administrative costs if managed care savings are shared with State and AEs.**

Answer to question 24:

The proposed Payment Model described in Part D Section 2 is based on three preliminary principles of payment as specified on page 19:

- All parties need some financial incentives to manage care – MCOs, AEs, State
- Partnership creates common priorities
- Risk potential must be adjusted based on meeting performance standards/quality metrics

EOHHS understands that this proposed financial model is a substantial change from the existing arrangement. We are seeking feedback on the advantages and disadvantages of such an approach, and specific recommended modifications that would better achieve the principles above and the objectives described in Part B on page 10.

Question 25: **Does the relationship between the MCO and the AE need to be "arms length" or, if an MCO is provider-owned, can the same organization of the leadership thereof sponsor an AE?**

Answer to question 25:

As described in Part C Section 3 Governance, the objective of the draft governance rules is to ensure that critical community participants are included in the leadership team of the Accountable Entity and that such participants have the ability to influence or direct clinical practice to improve outcomes.

The proposed governance requirements do not specify the MCO/AE relationship. However, EOHHS would appreciate comments as to whether such a relationship should be allowed or specified in the AE governance requirements in order to meet the objective above.

Question 26: **Are MCOs permitted to contract with a single AE?**

Answer to question 26:

The Draft Contractual Requirements specified in Part D would require that MCOs contract with certified Accountable Entities. EOHHS would appreciate comments as to whether MCOs should be required/permitted to contract with a certain number of certified Accountable Entities, all certified AEs, or some type of subset of certified AEs, and the advantages and disadvantages of such an approach.

Question 27: **Are the proposed terms in compliance with current and proposed CMS rules for managed care, particularly the proposed rule §438.6 Special Contract Provisions Related to Payment (F)(ii) that says the State may not set the amount or frequency of expenditures to value-based purchase contractors or recoup any unspent fund allocated for value-based purchasing?**

Answer to question 27:

EOHHS intends that any MCO contract terms would comply with current CMS rules for managed care.

Question 28: The proposed terms are highly specific with respect to the exact terms that the MCOs must offer AEs and suggest that over time all Medicaid members will be attributed to an AE. MCOs and AEs will each have governance, management, and care management costs. **What is the role of the MCO if all members will eventually be attributed to AEs? Isn't the dual structure inherently duplicative? Why wouldn't the state contract directly with AEs?**

Answer to question 28:

As explained in Part D, on page 16, EOHHS is specifically seeking feedback as to whether these requirements are drafted in sufficient detail to achieve the desired outcome or whether EOHHS should consider less detailed/specific requirements.

In Part D Section 1 the state also seeks comments as to the appropriate and responsive roles of the two parties. Currently, MCOs perform a variety of important functions on behalf of EOHHS and Medicaid enrollees, including utilization review/utilization management, claims processing, network contracting, grievances/appeals and member services.

Question 29: The minimum expected cost of care capture rate for AEs is 60% for Tier 1, 75% for Tier 2, and 90% for Tier 3. AEs will, by definition, be a narrow network. Because expensive tertiary care often needs to be referred out of network, 90% is a high capture rate for a narrow network even when use of the network is required. **Is a 60% initial capture rate realistic? Is a 90% ultimate capture rate realistic? How will an AE exercise this degree of control over members who are merely attributed and are permitted to seek care elsewhere?**

Answer to question 29:

As explained on page 12, the proposed "capture rates" of 60% for Tier 1 increasing to 90% for Tier 3, are intended to ensure that AEs are held accountable for a full spectrum of services, including primary, specialty, behavioral health, dental, and long term care services as appropriate to serve the specified population.

EOHHS would appreciate comments as to whether the specified capture rate is needed to support this intent, and what alternative standards the state might consider.

Question 30: Please define liability as referenced in Financial Requirements page 14. Does liability include accounts payable and incurred but not reported claims?

Answer to question 30:

EOHHS would welcome comments as to the specific components of liability for these purposes.

Question 31: Part C Section 5 – Organizational Capacity – cites a "…minimum of 5,000 Medicaid enrollees." Part E – Year 1 Pilot Program – cites "…at least 25,000 MMCO members." Will EOHHS consider a Year 1 Pilot Program that has less than 25,000 members?

Answer to question 31

EOHHS would appreciate comments as to the challenges and opportunities associated with the 25,000 minimum member requirement associated with the pilot.

Question 32: Please clarify, number of required copies. The RFI mentions a different number of required copies on Page 5 and Page 22.

Answer to question 32:

Please follow the response protocols specified on page 22.-"Submit one (1) original and five (5) complete copies of responses……"